

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 09-08-03.

The IRO reviewed ultrasound therapy, myofascial release, therapeutic exercises, office visits with manipulation, joint mobilization, regional manipulation, hot or cold pack therapy, electrical stimulation and therapeutic activities rendered from 01-16-03 through 04-15-03 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
1-16-03 through 3-20-03 (9 DOS)	97035	\$198.00 (1 unit @ \$22.00 X 9 DOS)	\$0.00	U	\$22.00	IRO DECISION	No reimbursement recommended.
1-16-03 through 3-20-03 (9 DOS)	97250	\$387.00 (1 unit @ \$43.00 X 9 DOS)	\$0.00	U	\$43.00	IRO DECISION	No reimbursement recommended.
3-20-03	97014	\$31.00 (1 unit)	\$0.00	U	\$15.00	IRO DECISION	No reimbursement recommended.
3-20-03	97010	\$15.00 (1 unit)	\$0.00	U	\$11.00	IRO DECISION	No reimbursement recommended.
1-16-03 through 4-15-03 (4 DOS)	97110	\$455.00 (1 unit @ \$35.00 X 13 units)	\$0.00	U	\$35.00	IRO DECISION	Reimbursement recommended in the amount of \$35.00 X 13 = \$455.00
1-16-03 through 4-15-03 (9 DOS)	99213-MP	\$432.00 (1 unit @ \$48.00 X 9 DOS)	\$0.00	U	\$48.00	IRO DECISION	Reimbursement recommended in the amount of \$48.00 X 9 DOS = \$432.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
1-21-03 through 4-15-03 (9 DOS)	97265	\$387.00 (1 unit @ \$43.00 X 9 DOS)	\$0.00	U	\$43.00	IRO DECISION	Reimbursement recommended in the amount of \$43.00 X 8 DOS = \$387.00
3-20-03	97530	\$60.00 (1 unit)	\$0.00	U	\$35.00	IRO DECISION	Reimbursement recommended in the amount of \$35.00
3-20-03	97260	\$75.00 (1 unit)	\$0.00	U	\$35.00	IRO DECISION	Reimbursement recommended in the amount of \$35.00
TOTAL		\$1,982.00					The requestor is entitled to reimbursement of \$1,344.00

The IRO concluded that ultrasound therapy (97035), myofascial release (97250) and electrical stimulation (97014) and hot/cold pack therapy (97010) from 01-16-03 through 04-15-03 **were not** medically necessary. The IRO concluded that therapeutic activities (97530), hot or cold packs (97010), regional manipulation (97260), joint mobilization (97265), office visits with manipulation (99213-MP) and therapeutic exercises (97110) from 01-16-03 through 04-15-03 **were** medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees (**\$1,344.00**). Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-09-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
11-20-02 through 2-14-03 (8 DOS)	97035	\$176.00 (1 unit @ \$22.00 X 8 DOS)	\$0.00	L	\$22.00	Rule 133.307 (g)(3(A-F))	Per the approved TWCC-53 the requestor was not the treating doctor; therefore, no reimbursement can be recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
12-2-02 through 12-6-02 (3 DOS)	97035	\$66.00 (1 unit @ \$22.00 X 3 DOS)	\$0.00	N	\$22.00	96 MFG MEDICIN E GR (I)(a)(iii)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$22.00 X 3 DOS = \$66.00
11-20-02 through 2-14-03 (9 DOS)	97250	\$387.00 (1 unit @ \$43.00 X 9 DOS)	\$0.00	L	\$43.00	Rule 133.307 (g)(3)(A-F)	Per the approved TWCC-53 the requestor was not the treating doctor; therefore, no reimbursement can be recommended.
12-2-02 through 12-6-02 (3 DOS)	97250	\$129.00 (1 unit @ \$43.00 X 3 DOS)	\$0.00	N	\$43.00	96 MFG MEDICIN E GR (I)(c)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$43.00 X 3 DOS = \$129.00
11-20-02 through 2-14-03 (9 DOS)	97110	\$980.00 (\$105.00 4 units X 8 DOS and \$140.00 4 units X 1 DOS)	\$0.00	L	\$35.00	Rule 133.307 (g)(3)(A-F)	Per the approved TWCC-53 the requestor was not the treating doctor; therefore, no reimbursement can be recommended.
12-2-02 through 12-6-02 (3 DOS)	97110	\$315.00 (\$105.00 4 units X 3 DOS)	\$0.00	N	\$35.00	96 MFG MEDICIN E GR (I)(b)	See rationale below. No reimbursement recommended.
11-20-02 through 2-14-03 (9 DOS)	99213	\$432.00 (1 unit @ \$48.00 X 9 DOS)	\$0.00	L	\$48.00	Rule 133.307 (g)(3)(A-F)	Per the approved TWCC-53 the requestor was not the treating doctor; therefore, no reimbursement can be recommended.
12-2-02 through 12-6-02 (3 DOS)	99213	\$144.00 (1 unit @ \$48.00 X 3 DOS)	\$0.00	N	\$48.00	96 MFG E/M GR (VI)(B)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$48.00 X 3 DOS = \$144.00
11-20-02 through 11-22-02	97265	\$86.00 (1 unit @ \$43.00 X 2 DOS)	\$0.00	L	\$43.00	Rule 133.307 (g)(3)(A-F)	Per the approved TWCC-53 the requestor was not the treating doctor; therefore, no reimbursement can be recommended.

(2 DOS)		2 DOS)					reimbursement can be recommended.
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DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
12-2-02 through 12-6-02 (3 DOS)	97265	\$129.00 (1 unit @ \$43.00 X 3 DOS)	\$0.00	N	\$43.00	96 MFG MEDICIN E GR (I)(c)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$43.00 X 3 DOS = \$129.00
TOTAL		\$2,844.00	\$0.00				The requestor is entitled to reimbursement in the amount of \$468.00

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

This Decision is hereby issued this 2nd day of June 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 12-02-02 through 04-15-03 in this dispute.

This Order is hereby issued this 2nd day of June 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dlh

December 5, 2003
Amended May 21, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-04-0143-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ fell six feet from a ladder that slipped out from under him on ___. He landed in such a manner that he broke the calcareous bone in his left foot, hurt his lower back and hurt both wrists. The fracture was diagnosed by Dr. ___ on 7/1/02. While a retrospective review by Dr. ___ on 5/24/03 stated that the carrier denied a back condition; complaints of lumbar pain were present on the date of injury as evidence by a lumbar spine study by ___ on 7/1/02. Injury to the wrists was noted by Dr. ___, P.A. in a NCV performed on 3/4/03.

There were six retrospective reviews from 8/4/03 through 6/19/03 by Drs. ___, ___, ___ and ___ (x3) that all found an adverse determination for various reasons. The respondent, however, submitted treatment and exam notes in its evidence that supported Dr. ___ care. The TXCC code 408.421 allows care that returns the patient to work, care that enables him to stay on the job, or care that decreases the patient pain.

The following show that the patient has an ongoing problem that is complicated and chronic in nature:

1/15/03 ___

Chiropractic care is helping. Patient not having to use crutches since 11/13/02. He is able to walk better. The pain is less. Patient is ready to go back to light duty work. Will need work hardening in about a month or so.

2/27/03 ___, M.D.

Lumbar block at L4 gave full relief of pain along with a positive temperature change.

3/5/03 ___, D.P.M.

Functional Capacity Evaluation showed limp affecting weight distribution and causing symptoms aggravation and biomechanical compensation.

3/12/03 ___, PhD.

Psychotherapy Exam showed stress adversely affecting patient to point intervention is recommended for biofeedback and psychotherapy sessions.

3/20/03 ___, M.D.

Lumbar block L3 and L4. Patient experienced an increase in ROM and an increase of 6F in his left foot. Patient to receive manipulation and physical medicine sessions.

6/13/03 ___, M.D., D.A.B.R.

MRI of lumbar spine revealed significant hypertrophy facet arthropathies bilaterally at L5 and S1, a 2-3 mm herniation (protrusion) at L5/S1.

Additional reports submitted by the respondent that are for care post Retrospective Reviews (4/8/03 – 6/19/03) show that the patient's symptoms were still present, and that the patient had actually returned to work (7/11/03, ___, M.D.) and that Dr. ___ was actively involved in his care.

6/27/03 ___, M.D.

Follow-up visit for left heel fracture, back pain and myofascial pain symptoms. Patient saw Dr. ___ and foot surgery approved by Worker's Comp.

7/11/03 ___, MD

He had to go to his primary care doctor for the pain because he had to take off two days off work.

8/15/03 ___, M.D.

Dr. ___ to do foot surgery in one month. Patient wearing an ankle boot and using a muscle stimulator.

8/15/03 ___, M.D.

Request for bone scan to help plan surgery

9/8/03 ___, M.D.

Bone scan revealed mild to moderate degenerative /post traumatic changes. No acute processes.

9/19/03 ___, M.D.

Recommendation made for talocalcaneal fusion.

DISPUTED SERVICES

The carrier has denied the medical necessity of ultrasound therapy 97035, myofascial release 97250, therapeutic exercises 97110, office visits with manipulation 99213-MP, joint mobilization 97265, regional manipulation 97260, hot or cold packs 97010, electrical stimulation 97014 and therapeutic activities 97530 from 1/16/03 through 4/15/03.

DECISION

The reviewer both agrees and disagrees with the prior adverse determination.

The reviewer finds for the medical necessity for the 97530, 97110, 99213, 97260 and 97265 procedure codes.

The reviewer does not find medical necessity for the 97010, 97035, 97250 and 97014 procedure codes.

BASIS FOR THE DECISION

Joint mobilization and manipulation were appropriate in this case. The reviewer finds for the medical necessity for the 97530, 97110, 99213, 97260 and 97265 procedure codes. This care was sustained by the requestor's evidence, the respondent evidence, or both.

The reviewer does not find medical necessity for the 97010, 97035, 97250 and 97014 procedure codes as Dr. ___ notes did not reflect that the service was performed, or that the service would benefit the patient at that point in the treatment, or that it was a service the patient could have easily performed at home.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,